AARP Kansas
555 S. Kansas Avenue
Suite 201
Topeka, KS 66603

T 1-866-448-3619
F 785-232-8259
1-888-687-2277
TTY 1-877-434-7598
www.aarp.org/ks

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The Honorable Jeff Colyer
Kansas Lieutenant Governor

Reference: Kansas Medicaid Budget

Greetings, Lieutenant Governor Colyer and Members of the Sub-committee for the review of the Kansas Medicaid program. My name is Ernest Kutzley and I am the Advocacy Director for AARP Kansas. We represent more than 341,000 members from across the state. Thank you for the opportunity to submit our comments and recommendations, for your review, on the Kansas Medicaid program.

We understand that these are troubling times, with budget shortfalls, and that budget scrutiny is necessary for all programs. As Kansas leaders and lawmakers consider state budget priorities and cuts, AARP Kansas is urging you to consider the benefits Medicaid funding brings to local economies while at the same time ensuring protection for Kansas' most vulnerable citizens.

Medicaid Is Vital To Older Americans, People with Disabilities and Our Entire Economy

Medicaid, which covers one out of six Americans, is a cornerstone of our nation's entire health care system and economy – especially in a time of economic crisis.

- Nearly 60 percent of all nursing home residents are covered by Medicaid.
- Medicaid helps millions of people who can't afford health care; families who have lost their jobs and those who need help until they get back on their feet.
- Medicaid is a financial foundation for many hospitals and health care providers. Even if you are not poor, the hospitals and health care providers you and your family rely on may not be able to survive significant Medicaid program cuts

Cutting Medicaid Harms State Economies

AARP understands that states face serious budget challenges, especially in the current economic climate. Yet research shows that cuts to Medicaid services and eligibility increase overall health care costs, and harm state economies by:

- increasing the number of people without health insurance and access to needed health care;
- increasing the burden of uncompensated care that doctors and hospitals provide;
- denying access to the long-term home and community-based services that keep the elderly and disabled out of more costly institutional care; and
- increasing long-range health costs, since people without coverage often go without necessary care and frequently develop worsening health conditions that could have been prevented.

Because the federal government matches state Medicaid funding by at least 2-to-1, a cut in state funding has a multiplier effect in terms of adverse impact on the state economy, business and jobs. Each dollar cut from state Medicaid funding reduces federal spending by $1.33 (on average) yielding a total reduction of $2.33 in health spending in the local and state economies.

In the absence of federal Medicaid dollars, hospitals will be forced to increase charges to other patients and their insurance companies. This "hidden tax" will increase the state's cost for medical insurance for state employees and retirees and result in higher premiums for business and individuals.

In 2014, the Medicaid program will be expanded to all individuals and families with incomes up to 133 percent of the Federal Poverty Level. If cut backs are made now, individuals left without health care coverage until then will return to Medicaid with worse health conditions and in need of more expensive care. Some will have developed chronic conditions that could have been prevented or mitigated by prevention and routine care.

Cutting Medicaid Threatens Jobs

Medicaid cuts often translate into job losses for hospitals, community health centers, nurses, mental health providers, technicians and other workers in facilities that serve Medicaid patients. Safety-net hospitals, community health centers, and nursing homes are major employers in many communities. These organizations also provide critical services to communities that extend well beyond people enrolled in Medicaid. For instance, many safety-net hospitals also serve as major trauma centers for accident victims.

Alternative to Medicaid Cuts

We urge states to maintain current Medicaid eligibility standards. Rather than cutting Medicaid eligibility now, states should seek to increase the efficiency and quality and to reduce fraud, waste and abuse.

The Affordable Care Act (ACA) provides new opportunities for states to contain Medicaid spending. These opportunities include additional funding for the states to improve care and efficiency for those eligible for Medicare and Medicaid. Most state Medicaid costs are attributable to the "dual eligible" population. The Affordable Care Act provides substantial new federal funding for state innovations to improve coordination of Medicare and Medicaid services to provide higher quality and more cost effective care. The ACA also provides added federal funding for states that expand lower cost home-based care while reducing reliance on more costly nursing home care.

We ask that you consider the following AARP policies as a guideline during your discussions on the Kansas Medicaid program. In the event that current Kansas Medicaid benefits exceed these recommendations, please do not consider a reduction in those benefits.

Medicaid Overview

Medicaid is the nation's largest publicly financed health insurance program for low-income parents, children, elderly, and people with disabilities. Children in low-income families may also gain access to Medicaid coverage through the State Children's Health Insurance Program (SCHIP). Low-income adults without dependent children who are not elderly, blind, or disabled are generally not eligible.

As a means-tested entitlement program, Medicaid requires states to provide coverage for individuals as long as they are members of a specified group and meet financial requirements.

There is evidence that some potentially eligible individuals are not enrolled in Medicaid, and many barriers to Medicaid enrollment have been identified. These include lack of information about the availability of Medicaid benefits, complex eligibility rules and enrollment processes, shortages of bilingual materials and program staff, fears related to immigration status, and reluctance by some to receive publicly funded benefits. Recently some states have begun imposing enrollment barriers to slow down program enrollment and expenditures.

Medicaid beneficiaries are entitled to have payment made on their behalf for covered services that are medically "necessary." With the exception of the Early and Periodic Screening Diagnosis and Treatment service, "medical necessity" is not defined in federal statute or regulation. Consequently states have discretion to define the term, and their definitions vary widely.

The federal government matches legitimate state Medicaid expenditures at a rate determined by the federal medical assistance percentage (FMAP). This formula, which has remained essentially unchanged since Medicaid's inception in 1965, is based on the relationship between each state's per capita personal income and the national average per capita personal income over three calendar years. FMAPs are based on per capita income data that have a multiyear time lag. Thus a state could receive a low FMAP based on per capita income data that reflect a strong economy at a time when the state has a weak economy. Conversely, states may get a higher FMAP during better economic times if the data used to determine the percentage are from a period when the state economy was in recession. These are known as countercyclical effects.

From time to time policymakers suggest financing Medicaid through a block grant. This is seen by some as a solution to rising program costs, a way to increase program flexibility, and a mechanism to improve program integrity. A block grant, sometimes referred to as global financing or a lump-sum allotment, is a fixed amount that the federal government gives to states for a specific program. If state costs for the program are higher than anticipated under the grant, the state has to make up the difference without additional federal assistance.

AARP is concerned that making Medicaid a block grant program would undermine the fundamental nature of the program as a safety net, because states may not be able to respond to increased needs for health care during economic downturns.

AARP Medicaid Policy

State governments should:

- ensure that all people living at or below the federal poverty level are covered by Medicaid,
- increase Medicaid participation among eligible people of all ages,
- ensure that crowd-out policies (e.g., policies designed to prevent people from dropping private coverage in favor of public coverage) do not result in loss of health insurance coverage for low-income children, and
- ensure the highest level of Medicaid participation among all health care providers.

Efforts to Restructure Medicaid Should:

- maintain the government's benefit guarantee, so that all who qualify for Medicaid will be covered, and maintain the entitlement nature of Medicaid funding—Medicaid funding should not be furnished through a block grant or limited for necessary services;
- maintain and improve current federal and state consumer protections; and
- adopt financing policies and payment strategies that do not compromise access and quality.

Eligibility and Services Expansion

States should maximize both all lawful opportunities for Medicaid-eligible individuals to receive benefits and alternative coverage from all third-party sources. In addition, states should use Medicaid's significant market power to foster the highest quality of health care for vulnerable citizens at the most reasonable price.

States should exercise available options for expanding Medicaid eligibility and services by offering:

- a program for the medically needy that is as generous as the federal government allows;
- coverage for pregnant women and infants whose household income is between 133 percent and 185 percent of the poverty guideline;
- full Medicaid coverage for people with disabilities and elderly people living at or below 100 percent of the federal poverty guideline;
- coverage using less restrictive income and asset tests, as authorized under Sections 1902(r)(2) and 1931(b) of the Social Security Act;
- coverage to low-income working adults, to the extent federal law allows (e.g., by disregarding the number of hours worked for two-parent households with dependent children);coverage to other groups, such as individuals who receive state support payments but are ineligible for federal Supplemental Security Income (SSI) benefits because of income levels;
- Programs of All-Inclusive Care for the Elderly (PACE) for people age 55 and older; and
- all available federal options to provide access to Medicaid through buy-in programs.

To improve Medicaid participation among those currently eligible, states should:

- conduct outreach activities and promote Medicaid and the State Children's Health Insurance Program (SCHIP) as a single, coordinated program of health insurance;
- avoid or reject policies that create barriers to continued enrollment (e.g., require more frequent recertification periods) during difficult economic times;

- monitor Medicaid participation rates and report enrollment rates on an ongoing basis, giving particular attention to underserved areas; and
- develop action plans to ensure that Medicaid and SCHIP coverage is appropriately maintained in geographic areas that either are underserved or have large numbers of people no longer eligible for welfare benefits.

Legal Assistance

States should establish legal assistance programs for Medicaid beneficiaries who have trouble obtaining services or paying their medical bills or believe a Medicaid claim was incorrectly processed or inappropriately denied.

Provider Contracting

State governments should conduct annual reviews to ensure that Medicaid's rules for paying providers and managed care plans do not threaten health care access. While preserving access, states should contract with cost-efficient, high-quality hospitals, physicians, and other providers to serve Medicaid beneficiaries. Payment incentive systems that reward high quality and improvements should be considered. Beneficiaries should be able to choose among providers who practice near beneficiaries' homes.

Medical Necessity

AARP, on a nationwide level, opposes the use of cost as the principal or determinative criterion in findings of medical necessity for Medicaid coverage. Where cost is a factor, it should be taken into consideration that higher initial costs may result in future savings.

Dual-Eligibles

Individuals eligible for both Medicaid and Medicare are referred to as dual-eligibles. There are several categories of dual eligibility. The largest consists of Medicare beneficiaries who are also eligible for full Medicaid benefits. These individuals tend to be either users of long-term care services or acute care users who depend on Medicaid for services that Medicare does not cover. Another important category of dual-eligibles receives assistance from Medicaid only to pay a portion of Medicare expenses. Under the Qualified Medicare Beneficiary (QMB) program, Medicaid pays the Medicare premiums, deductibles, and coinsurance for Medicare beneficiaries who have annual incomes at or below 100 percent of the federal poverty guideline and assets below a specified threshold.

Medicare beneficiaries with incomes between 100 percent and 120 percent of the federal poverty guideline and with limited assets—known as Specified Low-Income Medicare Beneficiaries (SLMBs)—are eligible to have their Medicare Part B premiums paid through state Medicaid programs.

Qualifying individuals (QI) are an additional category of dual-eligibles created by the Balanced Budget Act of 1997. Under the current QI program, which Congress must regularly renew, Medicare beneficiaries with incomes between 120 percent and 135 percent of the federal poverty guideline may have their Part B premiums paid by Medicaid. Because federal funding for the QI program is capped and allocated to states as grants, eligibility is extended on a first-come, first-served basis until each year's funds are expended.

The QMB, SLMB, and QI programs together are known as Medicare Savings Programs (MSPs). Fewer than about two-thirds of people eligible for QMBs or SLMBs are enrolled, but precise federal program statistics are unavailable. People receiving Medicare and full Medicaid benefits are eligible for and automatically enrolled in the low-income subsidy (LIS) for Part D drug coverage, which covers most drugs costs, except for nominal copayments. People enrolled in MSPs are also eligible for the LIS. States have the option to use less restrictive income-counting rules to raise income and asset limits for their MSPs, making more people automatically eligible for the LIS.

Duel Eligible Policy

Funding

The Medicaid program should be fully funded to ensure that all people eligible for the Medicare savings programs can receive Medicaid coverage.

Asset Test

The asset test for Medicare Savings Programs (MSPs) should be eliminated or made less restrictive. In the absence of new federal law, states should use existing statutory flexibility to eliminate or modify the asset test. A state can introduce less restrictive resource requirements by disregarding all resources or by allowing additional exclusions from countable assets.

Income Test

Where fiscally feasible, states should take advantage of the opportunity to increase income eligibility for their MSPs.

Enrollment

State governments should monitor Qualified Medicare Beneficiary (QMBs), (SLMB), and QI participation rates; report enrollment levels on an ongoing basis; and develop action plans in areas with low QMB, SLMB, and QI enrollment to ensure improved participation rates. Special attention should be given to problems of access in rural areas. State policymakers should work together to identify viable ways to use existing data sources to identify and enroll MSP eligible individuals.

Outreach

States should:

- simplify their administrative procedures so that eligible beneficiaries will more likely enroll in MSPs;
- develop simplified applications and consumer-friendly application sites, institute passive renewal processes, and eliminate burdensome documentation requirements;
- conduct innovative grassroots outreach to educate seniors about Medicaid, particularly the MSP—Innovations should include new outreach methods and sites, including by involving volunteer organizations; and
- make use of all available data to identify and enroll people eligible for MSPs.

Cost-sharing

State governments should be required to examine the extent to which nonpayment of the full Medicare deductibles and copayments for QMBs threatens access to care for these beneficiaries.

Waiver Programs

Strategies to reform Medicaid at the state level rely in part on exemptions from certain federal laws and regulations. These exemptions are collectively known as Medicaid waivers. There are a variety of waivers, each designed to allow states to accomplish specific policy objectives, such as covering services for some groups of people but not others, changing the delivery system, covering more people or a different mix of people, defining a new benefit package, and/or imposing new cost-sharing obligations.

The Medicaid statute gives states broad authority to waive many federal requirements. The waivers allow states expanded program flexibility so they can implement comprehensive or incremental reforms. The most fundamental requirement for all waivers is that they have a neutral effect on the federal budget. That is, federal Medicaid spending under the waiver cannot be more than federal spending without the waiver.

Under Section 1115 of the Social Security Act, the Department of Health and Human Services (HHS) can waive Medicaid eligibility, benefit, and service delivery requirements in the context of research and demonstration projects to promote program objectives. Many states have sought Section 1115 waivers to expand coverage to low-income individuals who may be ineligible for Medicaid because of the program's categorical or financial limitations. States also have sought waivers to integrate health and long-term care services using both Medicare and Medicaid funding, through programs such as social health maintenance organizations.

More recently states are seeking waivers to, among other goals, impose limits on spending for services to certain populations, offer different benefits to different populations, establish and/or increase enforceable premium and cost-sharing obligations for certain populations, and establish incentive accounts. Incentive accounts might allow a beneficiary to accrue points for engaging in healthy behaviors, and those points could be used to access services not normally provided by Medicaid.

States can also impose enforceable cost-sharing (above the nominal limit) on certain populations and offer different benefits to different populations through the state plan amendment (SPA) process. They also have the authority to enroll most Medicaid beneficiaries in managed care without going through the lengthy federal waiver process. Current Medicare waiver authority is limited to demonstration projects involving waivers of reimbursement requirements.

Waiver Programs Policy

General

State waivers from certain aspects of the Medicare and Medicaid statutes are appropriate and even desirable under certain circumstances. However, in order to safeguard existing coverage and maintain important protections, the criteria in this waiver programs section must be met. The waiver process should not be used to limit or cap spending for important benefits or necessary care. Budget neutrality should not be achieved by threatening existing services for eligible beneficiaries.

Eligibility

The entitlement nature of Medicaid should apply to expansion populations. Current prohibitions against enrollment caps, exclusions for preexisting conditions, or waiting periods should not be waived. Eligibility expansions should be consistent with the principle of covering those more in need before covering those less in need. For example, programs should not extend coverage to some people with income at 200 percent of the poverty guideline

Consumer Input

The waiver process and the state plan amendment (SPA) process must provide meaningful opportunities for public involvement at both the federal and state levels. As a precondition of waiver and SPA approval, states should demonstrate that there has been a meaningful public process and that the state has addressed public concerns.

The Department of Health and Human Services (HHS) should provide an opportunity for public comment on waiver requests as part of its approval process. Public comment and the state's response should be included in the application and made part of the administrative record.

The Centers for Medicare and Medicaid Services (CMS) should establish a waiver review panel that consists of consumers, providers, and federal and nongovernmental technical experts to receive testimony and comments and to recommend approval or disapproval of the waiver or any modification to it.

Beneficiary Impact Statement

States' waiver and SPA applications should include a beneficiary impact statement, analyzing the applications' expected effect on each beneficiary category, and a detailed explanation of the state's plan to monitor these effects continuously. CMS should define the categories and give the states guidance on monitoring.

Cost-Sharing

New cost-sharing and premium requirements should be permitted only if the HHS makes a reasonable determination that they do not deny access to needed care or create service barriers. Premium contributions should not be required of people with income at or below 100 percent of the federal poverty level. This population should have nominal cost-sharing obligations only if they do not hinder access to care. Premiums for people with income above 100 percent of the federal poverty guideline should not hinder access to needed services.

Coverage

Mandatory Medicaid services must be covered in the same amount, duration, and scope for all eligible people, regardless of eligibility category. Changes in benefits should not deny access to necessary care.

Adequacy of Provider Networks

Expansion populations should have adequate access to the same or comparable provider networks as those available to other non-expansion populations. Waivers that include Medicaid beneficiaries with disabilities, mental illness, or other complex health care needs must demonstrate adequate protections for these populations, including the adequacy of provider networks.

Personal Incentive Programs

Personal incentive programs created in waivers or by an SPA should not:

- be funded by redirecting money for necessary services,
- be administered in ways that penalize people who do not use such programs, or
- create incentives for people to deny themselves or their children necessary care.

Dual-Eligibles

Individuals eligible for both Medicare and Medicaid (dual-eligibles) must maintain their Medicare rights. There should be no mandatory enrollment in managed care.

Integrating Health and Long-Term Care

Existing Medicare and Medicaid waiver authority should be used to integrate health and long-term care under the following conditions:

- Beneficiaries must retain their rights to full Medicare and Medicaid benefits.
- There must be voluntary enrollment and disenrollment at any time.
- The ability of consumers to direct their own care must be ensured.
- Cost-sharing should be permitted only if it is not a barrier to receipt of services.
- Cost-sharing and other participation requirements must not result in coercive inducements to enroll or disenroll.
- Strong consumer protections, including an independent ombudsman program and external grievance procedure, must be in place.
- The state and CMS must provide strong and timely oversight.
- Consumers must participate in the development, implementation, and oversight of the waiver program.

- There must be strong quality assurance standards, including measures of functional and medical outcomes.
- Eligibility criteria for long-term services and supports should consider and appropriately measure the need for these services among people with physical impairments, mental impairments, and chronic illnesses. Determination of need should be based on measures of physical and mental functioning. Individuals should not have to meet medical criteria to be eligible for long-term care services.
- Contracting specifications should be adopted to ensure that a wide range of organizations is able to compete for the opportunity to manage the integrated systems. The organizations could include nonprofit, public, and community-based organizations; entities experienced in long-term care delivery; and managed care plans.

Quality and Consumer Protection

Quality assurance standards should include, at a minimum, internal and external quality review, meaningful grievance and appeals procedures, strong state monitoring and oversight (e.g., by an ombudsman), and strong sanctions for violations of quality standards.

Research Design

The research design component of Section 1115 waivers must be adequate to support waiver evaluation. At a minimum, states should be required to demonstrate that the research goals to be achieved through the waiver are measurable and that states have actual capacity to collect relevant data.

Quality and Consumer Protection

Policy

Efforts to restructure Medicaid should ensure that:

- long-term care services reflect the needs and preferences of beneficiaries and their families, and provide a choice between home and community support services and services in nursing facilities;
- quality protections are given the same priority as costs and access issues; and
- consumers have a strong voice.

Fraud and Abuse

In addressing fraud, waste, and abuse, federal and state governments should identify and implement strategies that do not threaten access to program benefits for low-income people and that direct savings back into the program.

Managed Care

States should adequately monitor contracted managed care entities to ensure that they comply with the quality and consumer protection standards outlined in the Balanced Budget Act of 1997.

Once again, thank you for this opportunity to provide these comments and recommendations for the Kansas Medicaid program. We respectfully request your support in protecting and enhancing the Medicaid program for current and future recipients.

Respectfully,

Ernest Kutzley

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Resource Data

State-specific data can be found in the Kaiser Foundation's Report: The Role of Medicaid in State Economies: A Look at the Research. http://www.kff.org/medicaid/7075a.cfm

State-specific federal matching share data: Federal Medical Assistance Percentage (FMAP) for Medicaid. http://aspe.hhs.gov/health/fmap11.htm

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